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G 000	INITIAL COMMENTS This Statement of deficiencies was generated as a result of the Medicare recertification survey conducted at your agency on August 4, 2008 through August 7, 2008. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The active census at the time of the survey was 465. 28 clinical records were reviewed. 10 home visits were conducted. The following regulatory deficiencies were identified:	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on the Nevada Nurse Practice Act, staff interview and clinical record review, it was determined that the agency failed to ensure that licensed staff complied with the professional standards and principles of practice that applied to professionals providing care, specifically identifying their title in written documents and providing care within their scope of practice for 2 of 28 patients reviewed. (Patient #7 and #4)	G 121		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	Continued From page 1 Findings include: Review of the Nevada Nurse Practice Act defined the difference between a registered nurse (RN) and a licensed practical nurse (LPN) as the following: 632.212 (2) A registered nurse shall demonstrate in the performance of those duties competence in: The diagnosis and treatment of human response to actual or potential health problems Exercising sound judgment Making decisions Carrying out his duties based on an established plan of care Evaluating, assessing and altering, if appropriate, the established plan of care Delegating appropriate duties to other nurses Supervising a nurse to whom he has delegated nursing duties Maintaining accountability in the delegation of care 632.230 A licensed practical nurse may not independently carry our those duties which required the substantial judgment, knowledge and skill of a registered nurse. A registered nurse assesses and evaluates health status of groups and individuals; collect objective and subjective data, analyze, report and record data A licensed practical nurse contributes to the assessment of health status by collecting, reporting and recording data. There was no evidence in the clinical record that the LPN reported her findings to the RN.	G 121		

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Review of the Nevada Nurse Practice Act: 632.249 Identification by appropriate title required, indicated that: Each registered nurse, licensed practical nurse, certified nursing assistant, nursing student and nurse certified in an advanced specialty shall identify himself by his appropriate title (a) when recording information on a record.

An interview with the Clinical Manager of the Reno office on 8/67/08, confirmed that all licensed staff were to incorporate their signature and discipline when signing documentation of the clinical record.

Patient #7: The patient was admitted to the agency on 10/24/07, with a primary diagnosis of carotid artery occlusion. Additional diagnoses included diabetes, edema, congestive heart failure and hypertension. Patient #7 remained a patient with the agency until 03/04/08, when she was discharged to the inpatient facility.

Review of the clinical record revealed several interim orders written by the registered nurse (RN). Interim orders were written on 11/26/07 to assess an injury to Patient #7's leg, and then subsequently on 11/27/07 and 11/28/07, for an additional visit to assess Patient #7's wound complications. An interim order was written on 01/25/08, for an additional skilled nurse visit to assess patient with symptoms or urinary tract infection (UTI) and obtain a urinalysis. An interim order was written on 02/08/08, for an additional skilled nurse visit to assess the patient following a fall. Review of the clinical record revealed that a licensed practical nurse (LPN) provided these interim visits. There was no evidence that the LPN communicated with the RN following her

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G 121	Continued From page 3 visits to report on her findings regarding Patient #7. The Nurse Practice Act revealed that an LPN could not assess, but rather gather data and report to the RN. The physician orders specified that Patient #7 was to be assessed for the changes in condition. Review of the clinical record also revealed the following: A telephone conference note on 10/27/07 and 10/28/07 was signed by an individual but there was no documentation of this individual's professional status. A Plan of care for 12/24/07-02/21/08 was signed by an individual but there was no documentation of this individual's professional status. An interim order on 02/08/08 was signed by an individual but there was no documentation of this individual's professional status. An interim order on 02/18/08 was signed by an individual but there was no documentation of this individual's professional status. The clinical nursing note on 03/17/08 was signed by an individual but there was no documentation of this individual's professional status. Patient #4: The patient was admitted to the agency on 02/25/08, with a primary diagnosis of obstructive chronic bronchitis. Additional diagnoses included hypertension, depression, diabetes and abnormality of gait. Patient #4 was seen twice a week for two weeks and then seen weekly by nursing.	G 121		

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G 121	Continued From page 4 Review of the clinical record also revealed that the clinical nursing note on 3/17/08 was signed by an individual but there was no documentation of this individual's professional status.	G 121		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on interview with agency staff and review of clinical records, it was determined that the agency failed to ensure agency staff administered care in accordance with the plan of care established by the physician for 4 of 28 patients. (Patients #13, #7, #4 and #20) Findings include: Patient #13: The patient was admitted to the agency on 05/17/08 with diagnosis of open wound of the hip/thigh, osteomyelitis multiple sites, anemia, infectious microorganism resistant to penicillin and depressive disorder. Skilled nursing was ordered for one time a week for one week, then three times a week for eight weeks and again one time a week for one week. The certification period was for 05/17/08 through 07/1/08. During the week beginning 05/18/08, skilled nursing only saw the patient two times. There was a missed visit documentation in the record that the patient was not seen. The physician was not notified of the missed visit. On the week starting 06/15/08, skilled nursing saw the patient	G 158		

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two times that week and there was a missed visit record in the documentation that the patient was not seen and there was no notification of the missed visit to the physician.

Patient #7: The patient was admitted to the agency on 10/24/07, with a primary diagnosis of carotid artery occlusion. Additional diagnoses included diabetes, edema, congestive heart failure and hypertension. Patient #7 remained a patient with the agency until 03/04/08, when she was discharged to an inpatient facility.

During the first certification period 10/25/07-12/23/07, Patient #7 was to be seen twice a week for one week, three times a week for one week, two times a week for two weeks, and then one day a week for the remaining five weeks by nursing.

The week of 11/25/07, Patient #7 was to be seen once. The clinical record revealed that there were three additional visits (PRN) ordered for 11/26/07, 11/27/07 and 11/28/07. The nurses' notes in the clinical record only reveal that there were prn visits on 11/26/07 and 11/27/07. There was no record that the prn visit for 11/28/07 was made. There was also no record that the regularly scheduled visit that should have been made the week of 11/25/07. There was no evidence that the physician was informed of the missed visits.
A physician's order was received on 12/06/07, for the agency to provide daily wet to dry dressings to affected leg ulcer. A skilled nurse visit was made 12/07/07. On 12/07/08 (Friday), a communication to was faxed to the physician informing the physician that the "patient experienced severe pain during dressing change even with saturating

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gauze. Also Medicare doesn't allow daily dressing changes by a home health nurse and patient doesn't have a consistent caregiver to teach. Would a Silvasorb gel dressing changed 2-3 times a week be an acceptable alternative". The physician's reply was to "Do wet to dry normal saline for 5 days and then switch to Silvasorb gel please". This reply was received by the agency on 12/10/07. There was no evidence that Patient #7 was seen on Saturday (12/08/07), Sunday (12/09/07), or Tuesday 12/11/08, as ordered and there was no evidence that the physician was informed that these visits were not made.

There was no evidence that the physician agreed to change the frequency.

An additional visit was ordered on 02/27/08 for assessment of hypoglycemia. There was no evidence in the clinical record that a nursing visit was made on 02/27/08. There was no evidence that the physician was informed that a visit was missed.

The recertification period for 02/22/08-04/21/08, started on a Friday. It was confirmed by the agency that their work week was Sunday through Saturday. The frequency for skilled nursing was one time a week for nine weeks; Physical therapy was twice a week for one week and then once a week for one week. The certified nursing assistant was twice a week for one week, but these visits were to start the week of 02/24/08, the first full week. Review of the visit notes revealed that nursing and therapy did not see Patient #7 on 02/22/08 or 02/23/08, or indicate that their visits were to start the first full week as the CNA's schedule indicated. There was no

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communication to the physician that there were missed visits, the first week (Friday and Saturday) of the new certification period.

Patient #4: The patient was admitted to the agency on 02/25/08, with a primary diagnosis of obstructive chronic bronchitis. Additional diagnoses included hypertension, depression, diabetes and abnormality of gait. Patient #4 was seen twice a week for two weeks and then seen weekly by nursing. An additional visit was ordered on 02/27/08 for assessment of hypoglycemia. There was no evidence in the clinical record that a nursing visit was made on 02/27/08. There was no evidence that the physician was informed that a visit was missed.

Patient #20: The patient was admitted to the agency on 07/07/08 with diagnoses including Diabetes Mellitus, neuropathy, anemia, and edema.

Record review revealed that the patient had missed visits on 07/10/08, and 7/23/08. No evidence that the physician had been notified of the missed visits for skilled nursing was found on the medical record.

The Clinical Manager was interviewed and reported that when a missed visit occurs, a "Missed Visit Form" was completed by the nurse and the form was then faxed to the physician. She reported that when the form was faxed to the physician, the physician's name and the date notified was filled in on the bottom of the form.

Record review revealed that the physician's name and the date notified sections of the missed visit

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G 158	Continued From page 8 form were found to have been blank.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the agency failed to ensure that the plan of care developed for patients covered all pertinent diagnoses, and instructions for care that were specific to each patient. The agency also failed to ensure that subsequent plans of care and goals reflected progression of appropriate, specific and progressive goals during the patient's care by the agency in 4 of 28 patients. (Patients #21, #16, #22 and #7) Findings include: An interview with the Clinical Manager on 08/05/08, revealed that the plans of care (485) and goals defined for each patient were not specific for each patient. She confirmed that statements were generic and did not specifically address the patients individual needs. She also confirmed that goals which should have been accomplished in one certification period continued unchanged for sequential certification periods,	G 159		

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G 159	Continued From page 9 without any demonstration of progression. Patient #21: The patient was admitted to the agency on 10/04/06 and continued care for a total of 11 certification periods. His primary diagnosis for the first two certification periods was "open wound of toe". His primary diagnosis for the last eight certification periods was cancer of the lung. Secondary diagnoses throughout his stay included chronic airway obstructive disease, circulatory disease, chronic ischemic heart disease, abdominal aortic aneurysm, cardiac dysrhythmia, atrial fibrillation. His diet was a regular diet for the first five certification periods and no concentrated sweets for the last six certification periods. He was seen three times a week for 10 weeks, twice a week for two weeks and then weekly from approximately 01/01/07 to his discharge on 07/11/08. Review of the clinical record revealed that Patient #21 only had three primary diagnoses ever identified. His diet plan changed from regular to no concentrated sweets. His plan of care contained the same goals throughout the 11 certification periods. These goals were: "The patient/caregiver will verbalize the nature of the primary/secondary diseases and complications in 9 visits. Verbalize the importance of compliance with diet, activities and medications in 9 visits." Only the time intervals varied. Additional goals remained unchanged when they appeared on subsequent plans of care. These goals were: "Verbalize the rational for appropriated hygiene care and prescribed skin care in 9 visits, Demonstrate compliance with prescribed oral medications in 9 visits. Demonstrate compliance with prescribed	G 159		

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dressing changes and wound care in 9 visits. Identify signs and symptoms of onset of wound infection in 9 visits." Other: Falls will be prevented continued for two certification periods.

For certification periods 4,5,6,7, 8, 9, 10, and 11, these goals remained unchanged, except for some variation regarding the time intervals; Verbalizes methods to obtain adequate caloric intake in 9 visits, Identify symptoms of fluid/electrolyte imbalance in 9 visits. Identify strategies to treat nausea and vomiting in 9 visits. Identify strategies to reduce risk of opportunistic infection in 9 visits. Demonstrate how to measure and record temperature in 9 visits. Demonstrate how to measure and recourse weight in 4 visits. Demonstrate effective pain control in 6 visits. Demonstrated appropriate coping strategies with physical and social limitations in 9 visits. Others: Falls will be prevented. Skin breakdown will be prevented.

Patient #16: The patient was admitted to the agency on 05/03/08, from the hospital with the primary diagnoses of cancer of the colon. His other diagnoses included lymphomas of the abdomen, open abdominal wound anemia and gastrointestinal hemorrhage. This certification period was from 05/03/08-07/01/08. He required recertification for a second recertification period from 07/02/08-09/30/08. At this time his primary diagnosis was deep vein thrombosis. His additional diagnoses included chronic leukemia, gastrointestinal hemorrhage, colon cancer and lymphomas of the abdomen.

Review of the plan of care and goals identified for each certification remained unchanged for the two certification periods, although the primary

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diagnosis did change. These goals were: Interventions: Knowledge deficit of disease process: Cancer, Assess : Physical/Psychosocial status q (every) visit. Assess/Teach: Complications of disease process, rationale for compliance with diet/Activities/Medications, methods to increase caloric intake. S/Sx (signs and symptoms) of fluid /electrolyte imbalance. How to treat nausea and vomiting. How to reduce risk of opportunistic infections. How to measure and record temperature. How to measure and record weight. Effective pain control, Coping skills. Identify strategies to treat nausea and vomiting in 4 visits. Identify strategies to reduce risk of opportunistic infections in 3 visits. Demonstrate how to measure and record weight in 2 visits. Demonstrate effective pain control in 3 visits. Demonstrate appropriate coping strategies w/ (with) physical and social limitations in 8 visits. Other: No falls, no opportunistic infections, patient will maintain weight at >170 pounds.

The plan of care and goals did not change between the two recertification periods although Patient #16's primary diagnosis changed. The primary diagnosis of deep vein thrombosis was not addressed at all in the second certification period.

Patient #22: The patient was admitted to the agency on 01/04/08 and continued to receive care for three additional recertification periods until her hospitalization on 07/24/08.

Review of the initial 485's plan of care on 01/04/08, revealed that the primary diagnosis was chronic ischemic heart disease with secondary diagnoses of chest pain, hypertension, asthma

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and shortness of breath.

Subsequent 485's identified the primary diagnoses as followed: Chest pain (03/04/08), Arthropathy (05/03/08) and congestive heart failure (07/02/08). Secondary diagnoses continued to repeat the diagnoses of arthropathy, edema, chest pain, hypertension, asthma and shortness of breath.

Review of the goals on all four 485's revealed that except for changing the compliance target of visits, the following remained the same: Patient/caregiver will: verbalize the nature of primary/secondary diseases and complications. Verbalize the importance of compliance with diet, activities and medications. Demonstrate competence and compliance with radial pulse measurements. Identify strategies of social adjustments to disease state limitations. Identify purpose of laboratory tests. Demonstrate compliance with prescribed anticoagulant therapy and its precautions. Demonstrate compliance with prescribed oxygen therapy and its precautions. Other: Falls will be prevented. Skin breakdown will be prevented.
Patient #7: The patient was admitted to the agency on 10/25/07 and discharged to an inpatient facility on 03/04/08, during her third certification period. Her primary diagnosis on admission was an open wound. Subsequent primary diagnoses included carotid artery occlusion and diabetes.
Review of the three certification plan of care goals revealed that the first and last certification included that the patient would: Verbalize the nature of primary/secondary diseases and complications. This goal was not included in the second certification period.

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G 159	Continued From page 13 All three certification periods included that that the patient would be able to verbalize diet, activities and medications by the end of each certification period. The Plan of care indicated that the diet remained unchanged, and the activities remained the same.	G 159		
G 303	484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. This STANDARD is not met as evidenced by: Based on clinical record review, policy review and staff interview, it was determined that the agency failed to demonstrate that discharge summaries were available to the physician in 9 of 28 patients. (Patients #21, #4, #12, #22, #8, #7, #2, #3 and #5) Findings include: Review of agency policies revealed that there was a policy identified as Discharge Criteria, and had been in effect since 12/92, and revised/reviewed 1/08. This policy described that part of the procedure was " A written discharge summary incorporating all involved disciplines is faxed to the physician. The original will be placed in the clinical record " . An interview with the clinical manager of the Elko branch office was conducted on 8/5/08. It was confirmed that the OASIS discharge form was used as the discharge summary. This form referred the physician to the previous	G 303		

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recertification summary. It was not an all inclusive summary of the patient ' s care and condition during the agency ' s provided care.
Patient 21: This patient was admitted to the agency on 10/4/06 and continued care for a total of 11 certification periods. His primary diagnosis for the first two certification periods was " open wound of toe " . His primary diagnosis for the last eight certification periods was cancer of the lung. Secondary diagnoses throughout his stay included chronic airway obstructive disease, circulatory disease, chronic ischemic heart disease, abdominal aortic aneurysm, cardiac dysrhythmia, atrial fibrillation. His diet was a regular diet for the first five certification periods and no concentrated sweets for the last six certification periods. He was seen three times a week for 10 weeks, twice a week for two weeks and then weekly from approximately 1/1/07.
Review of the clinical record revealed no discharge summary to reflect the care provided by the agency since 10/4/06 or Patient #21 ' s progress or decline.
On 7/11/08, Patient #21 was discharged from the agency to an inpatient facility. The care summary documentation on the discharge OASIS was " see 485, patient admitted to hospital after lung biopsy)
Patient #4: This patient was admitted to the agency on 2/25/08 with a primary diagnosis of obstructive chronic bronchitis. Additional diagnoses included hypertension, depression, diabetes and abnormality of gait. Patient #4 was discharged from the agency on 4/22/08, following a hospital admission for a fall. Patient #4 was seen twice a week for two weeks and then seen weekly by nursing. An additional visit was ordered on 2/27/08 for assessment of hypoglycemia. Nursing documentation also

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revealed that Patient #4 was exhibiting behaviors of self-isolation. A nursing visit on 4/21/08 revealed that Patient #4 had fallen. Patient #4 was having pain in the left hip and groin area and could not stand. She was sent to the hospital for emergency treatment.
There was no discharge summary in the clinical record to reflect Patient #4 ' s condition during the agency ' s care, the result of the additional visit or the fall and subsequent hospital admission.
Patient #12: This patient was admitted to home health on 2/20/08, following a physician ' s request. Her primary diagnosis was a decubitus ulcer of the hip. Her other diagnoses included emphysema, edema, abnormality of gait and debility. Skilled nursing was ordered two times a week for three weeks, and then weekly. Certified nursing assistant care was ordered weekly for one week and then twice a week for eight weeks. Patient #12 refused physical and occupational therapy.
Review of the clinical record revealed a decline in Patient #12 ' s general condition, possible end of life changes. A referral to Hospice was requested and on 3/3/08, home health care of Patient #12 was discontinued, and hospice accepted care. There was no discharge summary available in the record to reflect the care provided, and Patient #12 ' s declined condition for the 12 days that the agency provided care.

Patient #22: This patient was admitted to home health on 1/4/08 and was discharged to the hospital on 7/24/08. The transfer form indicated that Patient #22 required emergency transfer via ambulance to the hospital. Her hospital admission diagnoses included shortness of breath, atrial fib/flutter (which was a irregular and inadequate heart rhythm and function), anemia

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and possible gastrointestinal bleeding following a physician ' s request.
An interview with the primary nurse and Patient #22 on 8/5/08 at 3:30 PM, confirmed that the nurse was present at the time of transfer. The nurse related that Patient #22 was extremely short of breath, unable to even say more than one or two words. When assessed, Patient #22 ' s heart rate was very irregular.
There was no discharge summary available in the record to reflect the care provided from 1/4/08. The transfer form included the statement " see 485 " . Review of the 485 contained a summary of the previous recertification period which was: " clinical accomplishments by skilled nursing: No hospitalizations, no falls, no skin breakdown " . The 485 also included a clinical summary: " this 90 year old female with exacerbations of congestive heart failure, arthropathy and onset of dizziness. " The clinical summary included that Patient#22 ' s blood pressure range was 116/72-138/76. There were no other vital signs described. There was no documentation that several medications (Potassium and Lasix) had been changed or any summary of the subsequent effects of these changes for Patient #22.

Patient #8: This patient was admitted to the agency on 3/18/08. His diagnoses included dizziness and giddiness, cardiac dysrhythmias, open wound of the scalp, history of falls and orthostatic hypotension. He received nursing and physical therapy interventions. He was discharged to an inpatient facility following a fall at home on 4/22/08. Review of the clinical record revealed that a transfer OASIS completed on 4/22/08 indicated that the discharge summary was " see 485 " . Review of the 485 described the status of Patient #8 prior to the agency care,

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G 303	Continued From page 17 and did not describe any interventions that occurred since 3/18/08. Patient #7: This patient was admitted to the agency on 10/25/07, and discharged to an inpatient facility on 3/4/08, following a fall at home. She received nursing and aide services throughout the three certification periods, and physical therapy during the third. Review of the nursing notes indicated that Patient #7 required varying nursing visit frequencies to manage her care during these certification periods, as well as several unscheduled nursing visits for changes in her condition. Nursing care included wound management to her neck and leg ulcer wound, falls and urinary tract infection management. Review of the clinical record revealed that a transfer OASIS completed on 3/3/08 indicated that the discharge summary was " see 485 " . Patient #3: The patient was admitted to the agency on 09/07/08, with diagnoses that included decubitus ulcer, abnormal gait and history of fall. Record review revealed he was sent to an acute care facility on 02/25/08, due to a fall. He was discharged on 02/29/08. The care summary form dated 02/29/08, revealed that no summary of care was written. No summary of the patient's care could be found elsewhere in the patient's record. Patient #3 was readmitted to the agency on 03/19/08. Record review revealed that the patient was admitted to an acute care facility on 04/13/08, for kidney failure and a brain hemorrhage. The summary of care form dated 04/16/08, did not contain a summary of the patient's care to date. No summary of the patient's care could be found elsewhere in the	G 303		

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G 303	Continued From page 18 record. Patient #2: The patient was admitted to the home health agency on 01/07/08, with one re-certification period from 03/07/08 through 05/03/08, with diagnoses including chronic obstructive asthma, heart failure, abnormal weight loss, and malnutrition. On 08/05/08, Patient #2's medical record was reviewed. Review of the nursing visit note, dated 03/31/08, revealed that the patient was transferred to an acute care hospital on 03/31/08. A care summary for Patient #2 was completed on 4/1/08. The section to be completed for transfer to inpatient facility was to include reason for admission to home health and a summary of care to date. The written entry in that section was "See 485 (plan of care)". Patient #5: The patient was admitted to the home health agency on 01/06/08 with diagnoses including decubitus ulcer, abnormality of gait, and a history of falls. On 08/04/08, Patient #5's medical record was reviewed. A care summary was completed by the physical therapist on 01/24/08, after Patient #5 had completed her physical therapy, and detailed the patient's progress with physical therapy. Review of the medical record revealed the patient was admitted to an acute care hospital on 02/06/08, after falling at home. The care summary, dated 02/06/08, detailed the reason for hospitalization as "Patient fell at home." The section to be completed for transfer to inpatient facility was to include reason for admission to	G 303		

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G 303	Continued From page 19 home health and a summary of care to date. That area was blank. An interdisciplinary conference/contact form was completed on 03/04/08. The comment documented, "Certification expired while hospitalized. Discharged." Further review of the medical record failed to reveal a summary of Patient #5's care.	G 303		